October 11, 2016

The Honorable Carolyn N. Lerner
Special Counsel
U.S. Office of Special Counsel
1730 M Street, NW, Suite 300
Washington, DC 20036

RE: OSC File No. DI-16-2463

Dear Ms. Lerner:

I am responding to your June 1, 2016, letter referring for investigation two allegations made by a whistleblower at the Department of Veterans Affairs (VA) Montana Health Care System, Fort Harrison, Montana (hereafter, the Medical Center). The whistleblower alleged certain clinicians maintain an unofficial waitlist of Veterans seeking entry into the Medical Center’s residential treatment program for substance abuse disorders and that this practice is resulting in the delay of needed care, constituting a substantial and specific danger to public health. The Secretary has delegated to me the authority to sign the enclosed report and take any actions deemed necessary as referenced in 5 United States Code § 1213(d)(5).

The Under Secretary for Health directed the Office of the Medical Inspector to assemble and lead a VA team to conduct an investigation into these allegations. The report does not substantiate either of the two allegations, but makes one recommendation to the Medical Center, which the Medical Center has already addressed.

Thank you for the opportunity to respond.

Sincerely,

Robert D. Snyder
Chief of Staff

Enclosure
DEPARTMENT OF VETERANS AFFAIRS
Washington, DC

Report to the
Office of Special Counsel
OSC File Number DI-16-2463

Department of Veterans Affairs
VA Montana Health Care System
Fort Harrison, Montana

Report Date: September 30, 2016

TRIM 2016-D-1706
Executive Summary

The Under Secretary for Health (USH) directed the Office of the Medical Inspector (OMI) to assemble and lead a Department of Veterans Affairs (VA) team to investigate allegations lodged with the Office of Special Counsel (OSC) concerning the VA Montana Health Care System, (hereafter, the Medical Center) located in Fort Harrison, Montana. A person (hereafter, the whistleblower), who chose to remain confidential, alleged that employees are engaging in conduct that may constitute violations of laws, rules or regulations, and gross mismanagement, which may lead to a substantial and specific danger to public health. The VA team conducted a site visit to the Medical Center on July 5-8, 2016.

Specific Allegations of the Whistleblower

1. **Employee 1** and **Employee 2** are maintaining an unofficial waitlist of veterans seeking treatment from the Substance Abuse Residential Rehabilitation Treatment Program (SARRTP) in violation of Veterans Health Administration (VHA) Directives 1082 and 2010-027 and VHA Handbook 1160.04; and

2. Mismanagement of the SARRTP is resulting in the delay of substance abuse treatment, creating a substantial and specific danger to public health.

VA **substantiates allegations** when the facts and findings supported that the alleged events or actions took place and **does not substantiate allegations** when the facts and findings showed the allegations were unfounded. VA is **not able to substantiate allegations** when the available evidence is not sufficient to support conclusions with reasonable certainty about whether the alleged event or action took place.

After a careful review of findings, VA makes the following conclusions and recommendations.

Conclusions for Allegation 1

- **VA did not substantiate** that **Employee 1** and **Employee 2** are maintaining an unofficial waitlist of Veterans seeking treatment from the SARRTP/Substance Use Disorder (SUD) RRTP in violation of VHA Directives 1082 and 2010-027 and VHA Handbook 1160.04.

- The Acting Chief Behavioral Health (A/CBH) and Psychologist, Behavioral Health Services (P/BHS) do utilize a secure tracking sheet to record referrals, screenings, admissions, outpatient visits, and weekly contacts prior to residential treatment. Utilizing a tracking sheet is a common quality assurance practice to ensure Veterans receive adequate care.

- **VA confirms** that while the Medical Center is currently using the Patient Pending Bed Placement (PPBP) list within Bed Management Solutions (BMS), it is not utilizing it
as directed by VA guidance. Instead, it was providing the Veteran a general time frame for admission and waiting until the providers confirmed a discharge before adding the Veteran to the PPBP list in BMS.

- Waiting for a definite admission date prior to entry into BMS results in a discrepancy between the names on the Medical Center's tracking sheet and the names of Veterans pending residential admission in BMS on the PPBP list; however, it does not affect wait time reporting.

- The current process is not consistent with VA's recommended guidance on utilizing the PPBP list in BMS; however, we found no evidence that the Medical Center utilized this practice in an attempt to alter wait time reporting. And, this practice does not violate existing national directives.

- Significant turnover in facility and mental health leadership, compounded by a prior lack of established unit procedures for managing screenings and admissions (before Employee 1 and Employee 2) and their lack of understanding in how to determine a tentative admission date at the time of screening influenced the lack of conformance with VA guidance regarding the PPBP list.

- Since the leadership of Employee 1 and Employee 2, the SUD RRTP has been implementing policies and procedures to establish admission and discharge standards and guidance.

**Recommendation to the Medical Center**

1. On July 8, 2016, we recommended that the Medical Center immediately request and schedule a consultative site visit from the National Mental Health RRTP Program Office and complete additional training in the use of the PPBP list in BMS. The facility did so. Training was provided on August 1–2, 2016, as part of a site visit conducted by VHA's Office of Mental Health Services and Office of Mental Health Operations.

**Conclusions for Allegation 2**

- **VA did not substantiate** mismanagement of the SAR RTP/SUD RRTP nor did we find any delay of substance abuse treatment that created a substantial and specific danger to public health.

- The Medical Center provides timely access to the SUD RRTP for Veterans pending admission to the program. In addition, staff members track the Veterans' appointments while they are pending placement.

- Program and facility leadership have implemented a number of new policies and procedures since October 2015, in preparation for a Commission on Accreditation of
Rehabilitation Facilities review. These procedures have increased the structure and accountability associated with the screening and admission process.

- The timing of SUD RRTP admissions to coincide with the medical provider's schedule enabled the Medical Center to safely meet admission requirements.

- Direct feedback from Veterans in the SUD RRTP supports that the Medical Center is Veteran-centric in meeting their needs.


**Recommendation to the Medical Center**

None.

**Summary Statement**

OMI has developed this report in consultation with other VHA and VA offices to address OSC's concerns that the Medical Center may have violated law, rule or regulation, engaged in gross mismanagement and abuse of authority, or created a substantial and specific danger to public health and safety. In particular, the Office of General Counsel (OGC) has provided a legal review, VHA Human Resources (HR) has examined personnel issues to establish accountability, and the Office of Accountability Review (OAR) has reviewed the report and has or will address potential senior leadership accountability. VA found no violations of VA and VHA policy and notes that no substantial and specific danger to public health and safety is posed by current operations in the Medical Center's SUD RRTP.
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I. Introduction

The Under Secretary for Health (USH) directed the Office of the Medical Inspector (OMI) to assemble and lead a Department of Veterans Affairs (VA) team to investigate allegations lodged with the Office of Special Counsel (OSC) concerning the VA Montana Health Care System (VAMHCS), Fort Harrison, Montana (hereafter, the Medical Center). The whistleblower, who chose to remain confidential, alleged that two employees maintain an unofficial waitlist of Veterans seeking admission to the Substance Abuse Residential Rehabilitation Treatment Program (SARRTP) in violation of agency policy and directives. The whistleblower reported that the high risk Veterans on the unofficial waitlist are not being entered into the VA Bed Management Solutions (BMS) and are not receiving appropriate care, despite the availability of open beds in the SARRTP. The VA team conducted a site visit to the Medical Center on July 5-8, 2016.

II. Facility Profile

The Medical Center is a Joint Commission accredited, complexity level 2 facility serving Veterans across Montana, an area roughly 147,000 square miles in size. With more than 47,000 enrolled Veterans seen at 16 locations and 17 facilities, the Medical Center covers the state with one hospital on Fort Harrison, one Health Care Center in Billings, 12 Community-Based Outpatient Clinics (Anaconda, Bozeman, Cutbank, Glasgow, Glendive, Great Falls, Hamilton, Havre, Kalispell, Lewistown, Miles City, and Missoula), a Primary Care Tele-health Outreach Clinic (Plentywood), a Community Living Center (Miles City), and a Sleep Disorders Center (Helena).

The Medical Center is a 34-bed acute care (including 6 Intensive Care Unit (ICU) beds) medical-surgical facility offering a broad range of acute, chronic, and specialized inpatient and outpatient services, including internal medicine, gerontology, neurology, dermatology, cardiology, palliative care, pain management, medical oncology, surgery (general, vascular, laparoscopic, endoscopic), urology, orthopedics, plastic, ophthalmology, ENT, podiatry, gynecology, chiropractic care, and mental health, including outpatient treatment for substance use disorder (SUD) and posttraumatic stress disorder (PTSD).

The Medical Center also offers ambulatory care (primary care), and mental health (outpatient and residential) services. Its Radiology Service provides a broad range of diagnostic and interventional care on a full-time basis. In order to better serve Veterans in remote areas, its telemedicine services bring mental health, radiology, gynecology, primary care, ophthalmology, and tele-home health to them. It also operates a 24-bed Mental Health Residential Rehabilitation Treatment Program (MH RRTP) providing

1 Complexity Level 2: Complexity levels are determined by patient population (volume and complexity of care), complexity of clinical services offered, and education and research (number of residents, affiliated teaching programs, and research dollars). Complexity level 1 is the most complex and level 3 is the least complex; complexity for level 2 facilities is considered moderate. (VHA Executive Decision Memo (EDM), 2011 Facility Complexity Level Model).
specialized tracks for the treatment of PTSD and SUD; the latter track is known as SARRTP.

III. Specific Allegations of the Whistleblower

1. Employee 1 and Employee 2 are maintaining an unofficial waitlist of Veterans seeking treatment from the SARRTP in violation of VHA Directives 1082 and 2010-027 and VHA Handbook 1160.04; and

2. Mismanagement of the SARRTP is resulting in the delay of substance abuse treatment, creating a substantial and specific danger to public health.

IV. Conduct of Investigation

The VA team conducting the investigation included Employee 3, M.D., Deputy Medical Inspector (general surgeon); Employee 4, Registered Nurse (RN), Clinical Program Manager (CPM); and Employee 5, RN, CPM, all from OMI; Employee 6, Ph.D., Deputy Director, Mental Health Residential Rehabilitation Treatment Program, Mental Health Services; and Employee 7, PHR-CP, Human Resources (HR) Specialist, Veterans Integrated Service Network (VISN) 8.

VA reviewed relevant policies, procedures, professional standards, reports, memoranda, and other documents listed in Attachment A. We toured the Medical Center’s acute care facilities and the 24-bed mental health facility, which provides SUD and PTSD residential treatment.

VA also interviewed the following Medical Center employees:

- Employee 8, VISN 19 Mental Health Program Manager (VISN, PM)
- Employee 9, RN, Associate Director of Patient Care Services (ADPCS)/Acting Medical Center Director
- Employee 10, M.D., Acting Chief of Staff (A/CoS)
- Employee 11, M.D., Psychiatrist
- Employee 12, M.D., Medical Director, MH RRTP
- Employee 13, M.D., Primary Care Provider
- Employee 14, RN, Chief, Quality Manager
- Employee 15, RN, Patient Safety Manager
- Employee 16, Ph.D., Psychologist, Program Manager (PM)
- Employee 1, Licensed Clinical Social Worker (LCSW), Acting Chief Behavioral Health (A/CBH)
- Employee 2, Ph.D., Psychologist, Behavioral Health Services (P,BHS)
- Employee 17, Nurse Manager
- Employee 18, RN, Intake/Discharge Coordinator (IDC)
- Employee 19, RN
- Employee 20, LCSW
On July 13, 2016, we interviewed the following Medical Center employees via teleconference:

- Employee 21, LCSW
- Employee 22, LCSW
- Employee 23, Licensed Practical Nurse (LPN)
- Employee 24, Master Addiction Counselor (MAC), Licensed Addiction Counselor (LAC)
- Employee 25, Medical Support Assistant (MSA)
- Employee 26, Patient Advocate/Acting Congressional Liaison

V. Background

VA’s Domiciliary Care Program is the Department’s oldest health care program. The program’s original purpose was to provide a home for soldiers of the Civil War. In 1930, when the Veterans Administration was established, the National Homes for Disabled Volunteer Soldiers converted to domiciliary care to provide services to economically disadvantaged Veterans and remain committed to serving that group.

Since 1973, VA’s Office of Mental Health Services (MHS) has been responsible for ensuring that Veterans with SUD receive proper care. In accordance with title 38, United States Code (U.S.C.), § 1720A and title 38, Code of Federal Regulations (CFR), 17.38 and 17.80 through 17.83, VA provides SUD care to all eligible Veterans with these disorders. SUD care includes outpatient, inpatient, and residential treatment.

Pursuant to 38 U.S.C., § 1720A (d) (1), each medical center of the Department is to develop and carry out a plan to provide treatment for SUD, either through referral or direct provision of services, to Veterans who require such treatment. VA offers Veterans standard outpatient services; intensive outpatient programs; opioid replacement therapies; residential rehabilitation programs; and acute hospital services. The Medical Center also provides these services using telecommunications technology; by referral to other VA facilities or by sharing agreements, contracts, or non-VA care (to the extent that the Veteran is eligible to receive such care). Non-VA facilities that provide care for Veterans through sharing agreements, contracts, and fee basis care must provide access to their care and a level of quality consistent with VA standards.

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2 VHA Handbook 1160.04, VHA Programs for Veterans with Substance Use Disorders (SUD), March 7, 2012; Revised December 8, 2015.
These arrangements may facilitate access to SUD outpatient care within VA or provide access to non-VA services that complement VA programs.\(^3\)

VA offers SUD treatment to Veterans with alcohol and other drug-use illnesses that meet diagnostic criteria according to the Diagnostic and Statistical Manual of Mental Disorders (DSM-5).\(^4\)

VA provides services based on the clinical needs of an individual Veteran, in the least restrictive environment necessary to ensure their safety and promote their recovery. Not all patients require the entire continuum of services. Patients move among the components of the continuum in a clinically appropriate manner, with an emphasis on continuity of care to minimize disruptions in treatment and facilitate recovery in the Veteran’s community of choice.

Within primary care, general mental health, or other clinical settings outside of specialty SUD programs, patients with SUD may benefit from having specialized program staff involved in their assessment and treatment. SUD programs provide this support in cooperation with the primary provider. Specific arrangements vary from setting to setting. Providers clinically determine the length of treatment based on patients’ symptoms and their ability to function. As their recovery becomes more stable, their level of contact with VA providers generally decreases.

VA established the Psychosocial Residential Rehabilitation Treatment Program (PRRTP) bed level of care in 1995. This distinct level of mental health residential care served Veterans with mental health and SUD who required additional structure and support to address multiple and severe psychosocial deficits, including homelessness and unemployment.

In 2005, the Domiciliary Care programs fully integrated with the PRRTPs to become the Mental Health Residential Rehabilitation Treatment Programs (MH RRTP).\(^5\) MH RRTP provide a 24-hours-per-day, 7 days-per-week (24/7) structured and supportive residential environment designed to provide comprehensive treatment and rehabilitative services for Veterans with severe and complex mental health and/or substance use related treatment needs that often co-occur with medical and/or psychosocial needs. At the end of the second quarter, fiscal year (FY) 2016 there were 245 MH RRTPs with over 8,000 operational beds across VHA.

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3 VHA HANDBOOK 1160.04, VHA Programs for Veterans With Substance Use Disorders (SUD), March 7, 2012, Revised December 8, 2015.

4 DSM-5 is the standard classification of mental disorders used by mental health professionals in the United States and contains a listing of diagnostic criteria for every psychiatric disorder recognized by the U.S. healthcare system published by the American Psychiatric Association (APA). It is used by psychiatrists and other physicians, psychologists, social workers, nurses, occupational and rehabilitation therapists, and counselors. DSM is used in both clinical settings (inpatient, outpatient, partial hospital, consultation-liaison, clinic, private practice, and primary care) as well as with community populations.

5 VHA HANDBOOK 1162.02, Mental Health Residential Rehabilitation Treatment Program (MH RRTP), December 22, 2010.
MH RRTP is the term used to describe a broad continuum of programs that include:

- Domiciliary Substance Abuse (DOM SA) and Substance Abuse Residential Rehabilitation Treatment Programs (SARRTP), (hereafter, SUD RRTP).
- Domiciliary PTSD (DOM PTSD) and PTSD Residential Rehabilitation Treatment Program (PTSD RRTP), (hereafter, PTSD RRTP)
- General Domiciliary (GEN DOM) and Psychosocial Residential Rehabilitation Treatment Program (PRRTP), (hereafter, GEN RRTP)
- Domiciliary Care for Homeless Veterans (DCHV), and
- Compensated Work Therapy Transitional Residence (CWT-TR) Program.  

While the RRTP and Domiciliary bed sections have different histories, clinical practices and national policies are standard across the programs as outlined above.

VHA Handbook 1160.04, VHA Programs For Veterans With Substance Use Disorders (SUD), revised December 8, 2012, states that SUD RRTPs are not an appropriate level of care to provide acute medically managed or medically monitored detoxification to Veterans at moderate to severe risk of withdrawal. Veterans must meet the admission criteria for a SUD RRTP and be willing to participate in on-going treatment and rehabilitation as part of the residential continuum of care.

VA cannot deny Veterans admission to an SUD RRTP based solely upon length of current abstinence from alcohol or non-prescribed controlled substances, the number of previous treatment episodes, the time interval since the last residential admission, the use of prescribed controlled substances, or legal history. The screening process must consider each of these special circumstances and determine whether the program can meet the individual Veteran's needs while maintaining the program's safety, security, and integrity.

The Medical Center Services

In FY 2011, the Medical Center designated space within the facility to provide both acute inpatient mental health services and residential treatment. Its GEN RRTP became operational during July of FY 2011, and initially focused on treating Veterans with PTSD, and subsequently expanded to two specialty tracks, PTSD and SUD.

The SUD track referred to as the SARRTP in the allegations and hereafter as the SUD RRTP began operation in FY 2012. At the time the SUD RRTP opened, the residential program had 16 operational beds: 8 for patients with SUDs and 8 for patients with PTSD. Eight additional beds opened in October 2012, to provide Veterans with acute inpatient mental health services. However, these eight beds never became operational, due to nursing and provider staffing issues.

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6 VHA HANDBOOK 1162.02, Mental Health Residential Rehabilitation Treatment Program (MH RRTP), December 22, 2010.
The Medical Center Leadership decided to repurpose the beds and expand the number of residential beds by eight, resulting in 12 beds for Veterans with PTSD care and 12 beds for Veterans with SUD.

In accordance with VHA Directive 2009-001, *Restructuring of VHA Clinical Programs*, the VISN 19 Network Director submitted a restructuring request dated February 17, 2015, to the Deputy Under Secretary for Health for Operations and Management (DUSHOM). The Acting DUSHOM, the Acting Principal Deputy Under Secretary for Health and the Assistant Deputy Under Secretary for Health for Clinical Operations approved the request on March 25, 2015.\(^7\)

**National Policy and Guidance**

VHA Handbooks 1160.01 and 1162.02 outline current VA national policy related to access for residential treatment. Both handbooks focus on “timely” access for mental health residential treatment. VHA Handbook 1162.02 further states that, for SUD RRTPs:

Timely access to care is an important aspect of treatment engagement for patients in need of SARRTP [SUD RRTP]. Patients need to be informed promptly and updated frequently about their admission status; services need to be provided or arranged in the community during any interim from referral to admission.

On July 9, 2014, VA guidance sent to VISNs clarified VA’s expectations regarding access to residential treatment and how facilities should develop a system to monitor access nationally. The guidance, from the Assistant Deputy Under Secretary for Health for Clinical Operations, established VA’s initial expectations for access and explained how to capture wait times.

The guidance established the Patient Pending Bed Placement (PPBP) list within VA’s BMS as the official means for monitoring Veterans whose residential admission is pending. The program office uses this system to monitor access and not to generate wait time reports. It generates wait time reports utilizing the screening 596 stop codes until the time of admission. The program office uses the BMS and stop codes as a check and balance to better understand access issues.

From an attachment to the July 9, guidance:

VHA Directive 2010-027 titled “VHA Outpatient Scheduling Processes and Procedures” was never intended to require Electronic Wait List (EWL) utilization for measuring RRTP timeliness for admissions. The EWL is specific to outpatient scheduling and clinics and is not set up to monitor the time between

an admission decision and admission to the program as the Veteran is not new to residential care at this point as contact with the residential program has already been initiated.

The Directive does apply to management of consults and scheduling of appointments for screening for residential admission. As noted in previous guidance, all MH RRTP referrals must have an associated electronic consult for residential treatment with the 596 stop code designated as the first stop code associated with the consult (this occurs when the consult template is created and made available for use).

**Monitoring Veterans Pending Admission to the Residential Program**

When a Veteran is not able to be admitted on the day of screening, sites have established local processes that allow them to track pending admissions. If a site has a list of Veterans waiting for admission, they are required to monitor that list using guidelines specified by the Commission on Accreditation of Rehabilitation Facilities (CARF) standards.

In order to develop a national standard for how Veterans pending admission to a residential program are monitored, we expect that all facilities with MH RRTPs develop a timetable for inclusion of all residential treatment beds at the facility in the Bed Management Solutions (BMS) framework. Only BMS should then be used to document Veterans who are pending admission with Veteran scheduled within the system at the time of the admission decision.8

On August 21, 2015, in follow up to the July 9 memo, the Office of DUSHOM Communications, sent to VISN Directors and Administrative Representatives guidance highlighting the availability and wait time issue. It included this guidance:

Networks and medical centers operating an MH RRTP will utilize the Patient Pending Bed Placement (PPBP) list in Bed Management Solutions (BMS) to identify and monitor current Veterans pending admission to an MH RRTP. Those with wait times greater than 30 days must be offered alternative residential treatment or other services that meet their needs and preferences. After alternative treatment options are offered, some Veterans may choose to continue to wait for a bed in a specific program to become available which is acceptable, as long as any emergent needs including appropriate housing are met.

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8 From the email sent July 9, 2014 Assistant Deputy Under Secretary for Health Clinical Operations, VHA—Managing wait times for MH RRTP Admission.
Veterans must be screened for admission within 5 business days of the program receiving the referral or consult. Ideal access to an MH RRTP should occur within 72 hours from screening to admission. This timeframe is often critical for Veterans in early recovery from substance use, homeless Veterans and Veterans for whom outpatient care is not available or has been found to be ineffective. Any Veteran with an expected wait time of greater than 30 days must be offered alternative residential treatment or other services that meet the Veteran’s needs and preferences at the time of screening.

All Veterans waiting for admission to an MH RRTP must have weekly follow-up by the referral source and be provided access to other needed services, as appropriate. MH RRTP staff must collaborate with the referral source in this process.

Leadership in VHA, Central Office, required all networks to submit a VISN MH RRTP Strategic Access Plan in February 2016. The Office of Mental Health Services reviewed the plans. Each VISN received follow-up calls to discuss the proposed strategic actions.

Findings

**Allegation 1**

**Employee 1** and **Employee 2** are maintaining an unofficial waitlist of Veterans seeking treatment from the SARRTP [SUD RRTP] in violation of Veterans Health Administration (VHA) Directives 1082 and 2010-027 and VHA Handbook 1160.04.

We learned that before VHA recommended national implementation of the PPBP list in BMS, the facility had no formal process for managing referrals and admissions. Instead, the SUD clinical lead maintained a list with the names of Veterans interested in admission to the SUD RRTP.

In the past few years, multiple staff turnovers and leadership changes have occurred within Behavioral Health. P/BHS, a staff psychologist assigned to the RRTP, informed us that within the first couple of months of his being there, he also served as the unit’s admissions coordinator in August/September 2015. He told VA that, while serving as admissions coordinator, he received a spreadsheet from the unit’s program manager and used it as a tracking sheet to follow up on consults and the admissions process. At that time, only three people had access to this network secured word document.

On September 21–23, 2015, the Medical Center performed a review in preparation for their CARF review, (hereafter, a Mock CARF) and presented the findings to Medical Center leadership.
Among the issues the Mock CARF review identified was a concern that by the end of October 2015, the RRTP’s medical director and nurse practitioner would be leaving the Medical Center, and there were no immediate plans to cover those positions until after the CARF review.

The Medical Center rehired the former Behavioral Health Medical Director as a contractor, and he assisted several days a week, until the end of December. In addition, the Medical Center detailed a CBOC provider (FNP) as the Acting Chief of Behavioral Health (CBH). From October 2015 through April 2016, they also detailed a social worker, [the current Acting Chief of Behavioral Health (A/CBH)]. It tasked them both with improving issues the mock CARF report identified. They focused on improving the admissions process. With the support of the ADPCS, and the A/CoS, leadership moved a Full time Equivalent position to the RRTP to hire an RN as an intake admission coordinator.

Prior to the end of October 2015, the unit had two medical providers offering 80 hours of service per week; in November and December, only 9 hours of support for sick calls, admissions, discharges, and medical care was available. Therefore, the Medical Center modified admissions and discharges due to decreased medical coverage. Following patient safety practices, it only scheduled admissions and discharges on the days and times when medical coverage was available, as all admissions and discharges require the completion of a history and physical examination by a provider. According to current A/CBH, RRTP leadership never placed a hold on admissions, rather they scheduled admissions when the medical staff was available to appropriately admit and provide safe care in compliance with requirements.

We learned that a rumor spread throughout the Medical Center in January 2016, that the RRTP was going to close. The current A/CBH addressed the staff in a January 8, 2016, email:

There has been a rumor about the RRTP closing. This is not true. We are not closing the RRTP unit, nor have we been talking about closing the unit. We do not have this authority. This is a decision that can only be made at a VA Central office level, and only in the times of emergency.

The Medical Center continued to meet the medical needs of Veterans on the unit by assigning hospitalists, midlevel providers, Emergency Department (ED) staff, and the medical officer of the day to provide support until the unit’s new Medical Director, came on board March 21, 2016. She now completes medical histories, physicals, and discharges and also addresses all medical concerns of Veterans residing on the unit.

We reviewed the spreadsheet provided by P/BHS and spoke with staff members regarding local policies and procedures related to referrals, screenings, and admission to residential treatment at the Medical Center.
Screening/Admission Process

The intake/discharge coordinator (IDC) for the RRTP officially began her duties February 7, 2016. She explained her work to VA as follows:

When she receives a SUD consult for a Veteran, she reviews the document and contacts the Veteran. If the Veteran is interested in a residential program, she sends out a program application for him or her to complete and return. Each consult requires a completed application for admission to the program. If the Veteran is still at the Medical Center and is with his or her therapist, they may complete the application the same day; otherwise, it can take longer to complete.

When the IDC receives the completed application, she again contacts the Veteran by phone and conducts a screening interview. She also confirms the Veteran has ongoing outpatient therapy. In addition, she sends the consult information and application to the RRTP Medical Director and the assigned pharmacist to obtain clearance for the Veteran's participation in the program.

Every Monday, an interdisciplinary team (IDT) meets to review new applications and screening information to ensure that Veterans who have applied meet the criteria for the program. Members of the team include the IDC, the medical director, clinicians working on the unit, and the nurse manager. The team also triages the level of risk of each application they consider to determine which Veterans should have priority for admission.

After acceptance into the program, the IDC contacts the Veteran either on the same day as the IDT meeting or the next day and provides him or her verbally with an approximate time frame that a bed will be available. She records all contacts with Veterans on the consults.

These consults remain open until either the Veteran is given a firm bed date, the Veteran is admitted to another facility, or the Veteran decides to decline admission to the program. Also, if there is no response from the Veteran after three phone contacts and after a letter is mailed to the physical address that he or she provided on the application, the consult is closed. In addition, while Veterans await admission to the program, the Medical Center offers continuing outpatient services that meet their needs and priorities.

The IDC tracks consults on a spreadsheet, which she created and uses to follow, track, and maintain weekly contact with Veterans pending admission. The IDC told us that only staff members with a need-to-know have access to this spreadsheet located on a secure network site.

As part of the attention to admission processes initiated by Employee 1 and Employee 2, she reviewed all consults from the inception of the program and identified those without documentation of follow up. She made contact to ensure follow up; and,
to prevent this from occurring in the future, she uses the tracking sheet, stored on the VA secure network, to stay in weekly contact with all Veterans awaiting admission to the program. During this weekly contact, if the Veteran states he or she is doing well, is seeing a community provider, and does not want to come into the program, she closes the consult.

In addition, the IDC stated that when contacted, some Veterans are unable to come in at the time a bed is available. We learned that especially during the summer, some Veterans do not want to enter the program because they have vacation plans. When this happens, the IDC either offers the Veteran a choice of the next available bed date, or a referral to another VA facility.

If a Veteran has an acute medical need (e.g., is suicidal or needs detoxification, the Medical Center admits the Veteran for acute inpatient care, before participating in the SUDs program). After acute treatment, if the Veteran agrees, and a bed is available, the Medical Center may admit them to the RRTP or it may treat them as an outpatient.  

The IDC and the MSA stated that they do not enter the Veteran into the BMS until a definitive date for bed availability exists. Currently, the MH providers do not identify a tentative admission date for Veterans at the time of screening. Once a bed date is definitely available, the IDC informs the Veteran, and if he/she agrees to the date, then she enters the data into the BMS.

We reviewed VISN RRTP data on the BMS within the network. On December 9, 2015, the PPBP list identified 12 beds available on the unit with four Veterans pending admission. The Medical Center admits patients to the beds when the providers are available to complete the admission requirements.

We also found that from April 1, 2016, to June 30, 2016, the Medical Center had temporarily closed eight beds (one third) of the total number of RRTP to allow completion of a major plumbing-construction job. The work will eliminate a risk of Legionella bacteria contamination from poor water circulation. Because of the temporary closure, the Medical Center suspended one PTSD cohort and vacated two SUD beds.

VHA Directive 1082 requires the capture of outpatient encounters, inpatient appointments in outpatient clinics, inpatient mental health services, rehabilitation treatment program services, inpatient clinical pharmacy services, and billable encounters not captured elsewhere. It is not relevant to the issues addressed in these allegations.

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9 Detoxification is a set of interventions aimed at managing acute intoxication and withdrawal. It denotes a clearing of toxins from the body of the patient who is acutely intoxicated and/or dependent on substances of abuse. Detoxification seeks to minimize the physical harm caused by the abuse of substances. Treatment Improvement Protocol (TIP) Series, No. 45, Center for Substance Abuse Treatment. Rockville (MD): Substance Abuse and Mental Health Services Administration (US), 2006. http://www.nccic.samhsa.gov/books/NIH014115/
We reviewed the Medical Center's conformance data which reflects the percent of admissions with a documented screening visit, associated with the 596-stop code tied to the encounter. We found for the first quarter of FY 2015, the Medical Center had a 68 percent conformance rate with use of the 596 stop code. Subsequent quarters revealed a decrease in conformance rate through the fourth quarter of FY 2015 and early FY 2016 resulting in an inability to accurately capture the median wait time.

We also reviewed the Medical Center's February 2016 strategic access plan, in which the facility noted that "Substance Abuse track numbers show average wait time to be 141 days; further examination revealed that the 596 Stop Code was not being applied correctly in the SA screenings, so the data provided were erroneous." The Medical Center has improved its use of the 596 stop code as evidenced by a conformance rate of 89 percent during the third quarter of FY 2016, which exceeded the 85 percent benchmark.

The Medical Center's prior inconsistent use of the 596 stop code made our using the administrative data to calculate the SUD RRTPs wait times problematic. As a result, we conducted a manual review of the 273 Medical Center SUD RRTP consults submitted from August 2014 through July 2016. We measured the wait time from the day of consultation to the day of admission; the average wait time was 27 days.

Conclusions for Allegation 1

- **VA did not substantiate** that Employee 1 and Employee 2 are maintaining an unofficial waitlist of Veterans seeking treatment from the SUD RRTP in violation of Veterans Health Administration (VHA) Directives 1082 and 2010-027 and VHA Handbook 1160.04.

- The A/CBH and P/BHS do utilize a secure tracking sheet to record referrals, screenings, admissions, outpatient visits, and weekly contacts prior to residential treatment. Utilizing a tracking sheet is a common quality assurance practice to ensure Veterans receive adequate care.

- VA confirms that while the Medical Center is currently using the PPBP list within BMS, it is not utilizing it as directed by VA guidance. Instead, it was providing the Veteran a general time frame for admission and waiting until the providers confirmed a discharge before adding the Veteran to the PPBP list in BMS.

- Waiting for a definite admission date prior to entry into BMS results in a discrepancy between the names on the Medical Center's tracking sheet, and the names of

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10 VHA Decision Support System (DSS) Identifiers, also known as stop codes, are three-digit, standardized codes used to characterize services provided by VHA outpatient clinics. DSS Identifiers indicate the work group responsible for providing the specific set of clinic products and serve as a stable identification method that can be used to compare program activity between facilities. The 596-stop code records patient visits for individual evaluation, consultation, follow-up, and treatment provided by the facility's formal Substance Abuse Treatment Program.

11 Wait times are monitored quarterly (defined as the time between the first screening visit and subsequent admission) using administrative data. Prospective monitoring of Veterans pending residential admission occurs locally using the PPBP list within BMS and monitored monthly by MHS.
Veterans pending residential admission in BMS on the PPBP list; however, it does not affect wait time reporting.

- The current process is not consistent with VA's recommended guidance on utilizing the PPBP list in BMS; however, we found no evidence that the Medical Center utilized this practice in an attempt to alter wait time reporting. And, this practice does not violate existing national directives.

- Significant turnover in facility and mental health leadership, compounded by a prior lack of established unit procedures for managing screenings and admissions, (before Employee 1 and Employee 2), and their lack of understanding in how to determine a tentative admission date at the time of screening influenced the lack of conformance with VA guidance regarding the PPBP list.

- Since the leadership of Employee 1 and Employee 2, the SUD RRTP has been implementing policies and procedures to establish admission and discharge standards and guidance.

Recommendation to the Medical Center

1. On July 8, 2016, we recommended that the Medical Center immediately request and schedule a consultative site visit from the National MH RRTP Program Office and complete additional training in the use of the PPBP list in BMS.

   In response to this recommendation, on August 2-3, 2016, MHS and the Office of Mental Health Operations conducted a site visit to the Medical Center, MH RRTP. The purpose of this visit was to immediately respond to the recommendation and provide consultation related to MH RRTP operations including management of screening and admissions and broader conformance with national policy. The scope of the site visit included consultation on the MH RRTP continuum of services resulting in a report to the facility highlighting areas of strong practice as well as areas for improvement specific to the areas of consultation requested. During the team's visit, they shared strong practices noted in other residential programs, while also responding to specific consultation questions from the facility. During the site visit, the team reviewed residential program staffing, access, clinic data, program offerings and current policies and procedures. The team also toured the residential environment of care to review safety, security, and supervision of the unit.

Allegation 2

Mismanagement of the SARRTP is resulting in the delay of substance abuse treatment, creating a substantial and specific danger to public health. The whistleblower further reported that Veterans were waiting for significant periods for admission to the SUD RRTP and voiced concern for their safety. In addition, the whistleblower alleged that the unit had unfilled beds while Veterans were pending admission.
VHA Directive 2010-027 requires the VA to "create appointments that meet the patient's needs with no undue waits or delays."

We spoke with staff and Veterans regarding local policies and procedures related to program access and the management of the SUD RRTP. As noted in the background of this report, the Medical Center expanded the number of residential beds when the acute inpatient mental health unit closed. This decision addressed a need for additional residential resources the facility itself had identified.

In the fall of 2015, the RRTP program experienced an unexpected gap in medical provider staff coverage, as reported above in Allegation 1's findings. The unit went from two providers, offering 80 hours of support per week, down to nine hours of support per week to cover sick call, admissions, discharges, and other medical care. As a result of the staffing issues in December and early January, and citing patient safety concerns, the A/CBH limited the time periods for admissions and discharges to ensure medical staff coverage to meet admission requirements.

In preparation for a CARF visit, program and facility leaders have implemented a number of new policies and procedures since October 2015. These procedures have increased the structure and accountability associated with the RRTP's screening and admission process. VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, paragraph 12.i. requires that staff maintain contact with Veterans while they are pending residential treatment. We found evidence in the Veterans' electronic medical records that demonstrated the Medical Center's high level of engagement with Veterans during the time they were waiting for residential admission. New RRTP staff, especially the IDC, demonstrated and documented meeting this standard.

We spoke with four Veterans currently participating in the SUD RRTP. Each confirmed that program staff remained engaged with them while they were awaiting care.

**Veteran #1**

Within a day or two, I was called by the IDC, and she gave me an overview of the program and kind of how things worked. She called every week, gave me an update. The last week in she called me and said that there was a bed available. I had some stuff I needed to take care of around financial things, and I asked to be given another week, which she agreed to. And the following week, I entered the program. The program has been really great. I’ve been to a couple of treatment programs before, and this one here is, by far, the best. It’s given me a lot of tools for my recovery; everything from spirituality to cognitive-behavioral therapy, art therapy, horse therapy.

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12 VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008; Amended November 16, 2015.
Veteran #2

It took about a week to get contacted. My next contact was when I ended up in the hospital here. The IDC came up and saw me. I couldn't go right away. They actually tried to bump me up, and I'm the one that said, No, I have to go home and take care of stuff. Yeah, they were going to move me up, and I said I needed just a little bit of time. I didn't have any clothes with me or anything like that. Within a week, I was admitted for the SUDS program. The program is working out great.

Veteran #3

I went in a Vet Center, asked for some help, and they referred me over here. Someone contacted me and conducted an interview over the telephone. It was a couple of weeks after contact to a bed date. My case was a little different. I think I probably skipped my first bed date. I was in residential care for PTSD and substance use the end of [redacted] and through the beginning of [redacted]. I did two programs. I probably should have listened to myself and gone back to the substance use program. I did not feel ready to go home when I finished with my PTSD, but I was ready to go home -- I wanted to go home, so I did. I relapsed. I called back and I was back in the program in just a couple days. I like the program here. The staff has a lot of experience. They incorporate lot of Native American ceremony and tradition.

Veteran #4

The IDC gave me a call and asked, “How am I doing?” She wanted just to make sure how I was doing mentally inside. I said, you know, 50/50. And so she said, “Do you need to come now, as in now, or, you know, do you think it was all right?” And I was like, you know, I think I'm still all right. My wife was having shoulder surgery at the same time. And I said, if I could go, you know, a week or two, I think I could last that long, because I've got to take care of my wife. But she actually called me the next week and said, “Hey, we've got a bed open. Do you think she's okay for you to come in?” And I was like, Can I go another week? And she said, “Sure.” And they had me set up for the Wednesday after. The process was great. It was very informative; in other words, you were not just left out on the dark. The program here is, is exceptional. You know, it is very well maintained. It is very well run. With my medical experience, you know, it's very hard to fool me, and they're genuine. The groups are very well run.
Consult Review

The A/CBH stated that sometime in January or February 2016, they looked at the processes then in place for consult reviews, and realized the processes had significant issues. As a result, the Medical Center conducted a full review, for both the SUD and PTSD tracks, of all consults for the RRTP and all applications for the program submitted by Veterans.

As noted above, the Medical Center team reviewed all consults since the beginning of the program, to ensure that they included every Veteran referral. The A/CBH and the IDC told us they found many consults that were either open, or for which there was no documentation. In addition, the A/CBH stated that outpatient behavioral health services followed any Veteran waiting for placement until a program bed became available.

The IDC and other Medical Center staff reviewed 188 consults from 2014 to the time of the review. The Medical Center contacted Veterans with consultations that had not been closed, and asked them if they were still interested in participating in the program. In addition, staff contacted individual Veteran’s therapists to find out if the consults were still appropriate.

On February 12, 2016, the Medical Center submitted an issue brief to VISN 19 on the SUD RRTP. It stated that:

We are currently revamping our admission and discharge process for the MH RRTP. During this initiative, we conducted a 100% review of all previous requests of services to both PTSD and SARRTP [residential] programs. This included reviewing all applications and consults to both programs.

On 2/11/16, during the review of old consults for admission to the SARRTP [SUD RRTP] unit, it was discovered a Veteran who had applied for the program in □/2015 for his alcohol dependence, died on □/2015 with the cause of death being Alcoholic Cirrhosis.\(^{13}\) A current review of the Veteran’s record completed by the Veteran’s Primary Care Provider and Interim Chief of Behavioral Health indicated that due to this Veteran’s end stage cirrhosis and other medical conditions, he would not have been a viable candidate for residential treatment and that residential treatment would not have changed the outcome for this Veteran.

We reviewed 273 consults for 252 unique Veterans from August 2014 through June 2016. Of those consults, 125 did not result in admission into the SUD RRTP. Of the 125 consults:

- 66 were withdrawn, refused by the Veteran, or entered erroneously;

\(^{13}\) Alcoholic liver disease occurs after years of heavy drinking. Over time, scarring and cirrhosis can occur. Cirrhosis is the final stage of alcoholic liver disease. https://medlineplus.gov/ency/article/000281.htm
• In 43 consults, the Veteran elected to initiate or continue outpatient treatment;
• In 16 consults, another program had admitted the Veteran.

All (100 percent) of the Veterans who either were discharged from the SUD RRTP or were admitted to other VA facilities for substance abuse treatment received follow-up contact and care.

We reviewed consults since October 2015, to determine the impact of the A/CBH and P/BHS assignments to the SUD RRTP. We found the total number of consults had more than doubled since their arrival, and that the average length of stay in the program has decreased from 56 days to 43 days.

As we mentioned in our findings related to Allegation 1, the Medical Center had not been using VA’s stop codes system appropriately and postponed entering a Veteran into the PPBL in BMS until a firm date was available. Therefore, utilizing this data would not give an accurate picture of the Medical Center’s SUD RRTP’s availability or wait time. As a result, as noted in Allegation 1, we conducted a manual review of each consult, from day of consultation to day of admission and calculated that Veterans waited an average of 27 days for admission into the program.

In our review of the consults, we found the Medical Center offered each Veteran the opportunity to participate in outpatient treatment while pending admission to the SUD RRTP. In addition, upon discharge from the program, each Veteran received a follow-up phone call and/or an appointment with an addiction therapist, mental health counselor, case manager, or staff from the Medical Center’s Homeless Veteran program.

We found that three Veterans of the 252 reviewed cases died within the past year; one due to alcoholic cirrhosis and two due to undetermined causes. In each of these cases, the deceased Veteran had refused multiple referrals for SUD treatment and also had multiple co-morbid conditions. 14

Conclusions for Allegation 2

• VA did not substantiate mismanagement of the SARRTP/SUD RRTP nor did we find any delay of substance abuse treatment that created a substantial and specific danger to public health.

• The Medical Center provides timely access to the SUD RRTP for Veterans pending admission to the program. In addition, staff members track the Veterans’ appointments while they are pending placement.

• Program and facility leadership have implemented a number of new policies and procedures since October 2015, in preparation for a CARF review. These

14 Comorbid is defined as any condition existing simultaneously with and usually independently of another medical condition. http://www.merriam-webster.com/dictionary/comorbid
procedures have increased the structure and accountability associated with the screening and admission process.

- The timing of SUD RRTP admissions to coincide with the medical provider’s schedule enabled the Medical Center to safely meet admission requirements.

- Direct feedback from Veterans in the SUD RRTP supports that the Medical Center is Veteran Centric in meeting their needs.

- Review of the Veterans’ electronic medical record and consults do not substantiate a delay in SUD treatment.

Recommendation to the Medical Center

None.

VI. Summary Statement

OMI has developed this report in consultation with other VHA and VA offices to address OSC’s concerns that the Medical Center may have violated law, rule or regulation, engaged in gross mismanagement and abuse of authority, or created a substantial and specific danger to public health and safety. In particular, OGC has provided a legal review, VHA HR has examined personnel issues to establish accountability, and the OAR has reviewed the report and has or will address potential senior leadership accountability. VA found no violations of VA and VHA policy, and notes that no substantial and specific danger to public health and safety is posed by current operations in the Medical Center’s SUD RRTP.
Attachment A

Documents reviewed in addition to the Electronic Medical Records review.

Office of the Assistant Deputy Under Secretary for Health for Clinical Operations (ADUSH) communication email, VHA---Managing wait times for MH RRTP Admission, July 9, 2014.

Office of the DUSHOM communication email to VISN Directors, VHA VISN Admin Reps, August 21, 2015.


VHA Handbook 1160.01, Uniform Mental Health Services In VA Medical Centers And Clinics, September 11, 2008 (Amended November 16, 2015).

VHA Handbook 1162.02, Mental Health Residential Rehabilitation Treatment Program, December 22, 2010.

VHA Handbook 1160.04, VHA Programs For Veterans With Substance Use Disorders, March 7, 2012 (Revised December 8, 2015).


VHA Issue Brief, VISN 19 – VA Montana Health Care System, Fort Harrison, Montana, PTSD Residential Rehabilitation Treatment Program (RRTP) resident intoxicated while on pass, February 16, 2016.


VHA Surgical Complexity listing of all VHA Facilities
https://vaww.nso1.med.va.gov/vasqip/DUSHOMembeddedPages/complexity.aspx
VA Montana Health Care System (VAMHCS) Behavioral Health Organizational Chart, June 2016.

VAMHCS Center Circular Number 11-12-31, Admission Policy and Procedures for the MH RRTP, SA (Mental Health Residential Rehabilitation Treatment Program, Substance Abuse Track), July 12, 2012.


VAMHC Mental Health Executive Council Meeting Minutes, January – April 2016.


VAMHCS MH RRTP, Screening Application, June 29, 2016.


VAMHCS Proposed Restructuring of Clinical Programs or Services Requiring Under Secretary for Health Approval, February 17, 2015.
